TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Simon J. Forster, D.C.

Respondent Name
Comppac Trust of Texas

MFDR Tracking Number
M4-17-1898-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
February 21, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The code 97750 is code for functional testing … This assessment is more appropriate to utilize when specific functional tests are required to answer a question pertaining to specific functional ability, (without requiring a complete assessment comprised of all the 14 sub-component element requirements outlined in TAC §134.204(g) for a full functional capacity evaluation, which in turn is billed as 97750-**FC** according to TAC §134.204(n)(3)).

The code 97750 was performed following a Designated Doctor referral and therefore billed in conjunction with '99456-**W5** … ***Any additional testing is performed separately to the exams, and not as a component of the exams.***"

Amount in Dispute: $157.47

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The denial for reimbursement is based on a billing error. At the time of reconsideration we included a message on 97750 that stated, 'If this is a distinct and separate procedure it must be billed with the appropriate modifier to indicate it is a separate and distinct procedure.' … The 59 modifier represents a distinct and separate service."

Response Submitted by: Review Med

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 21, 2016	Physical Performance Test (97750)	$157.47	$132.59

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
3. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating provided on or after September 1, 2016.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - Note: "National Correct Coding Initiative edit – either mutually exclusive of or integral to another service performed on the same day."
   - 236 – This procedure or procedure/modifier combination is not compensable with another procedure or procedure/modifier combination provided on the same day according to the NCCI edits or work comp state regs/fee schedule requirements.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - Note: "IF THIS IS A DISTINCT AND SEPARATE PROCEDURE IT MUST BE BILLED WITH THE APPROPRIATE MODIFIER TO INDICATE IT IS A SEPARATE AND DISTINCT PROCEDURE."

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is Simon J. Forster, D.C. entitled to reimbursement for the disputed services?

Findings

1. Dr. Forster is seeking reimbursement of $157.47 for a physical performance test in conjunction with a designated doctor examination he performed. The date of service for the service in question is November 10, 2016.

   Comppac Trust of Texas (Comppac) denied disputed services with claim adjustment reason code 236 – "This procedure or procedure/modifier combination is not compensable with another procedure or procedure/modifier combination provided on the same day according to the NCCI edits or work comp state regs/fee schedule requirements." Comppac included the following notes on its review analyses:

   - "National Correct Coding Initiative edit – either mutually exclusive of or integral to another service performed on the same day."
   - "IF THIS IS A DISTINCT AND SEPARATE PROCEDURE IT MUST BE BILLED WITH THE APPROPRIATE MODIFIER TO INDICATE IT IS A SEPARATE AND DISTINCT PROCEDURE."

   28 Texas Administrative Code §134.250(5) states, "If the examination for the determination of MMI and/or the assignment of IR requires testing that is not outlined in the AMA Guides, the appropriate CPT code(s) shall be billed and reimbursed in addition to the fees outlined in paragraphs (3) and (4) of this section."

   Further, 28 Texas Administrative Code §134.203(a)(7) states, in relevant part, "Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by CMS in administering the Medicare program."

   Because the service in question is additional testing to aid in the determination of maximum medical improvement and impairment rating, CMS policies, such as the National Correct Coding Initiative does not apply. Comppac's denial reason is not supported.

2. 28 Texas Administrative Code §134.203(c) states,

   > To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   > (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83…

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year…

The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the division conversion factor. The division conversion factor for 2016 is $56.82.

For CPT code 97750 on November 21, 2016, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.000 is 0.45. The practice expense (PE) RVU of 0.46 multiplied by the PE GPCI of 1.019 is 0.46874. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. The reduced PE for subsequent units is 0.23437. The malpractice RVU of 0.02 multiplied by the malpractice (MP) GPCI of 0.766 is 0.01532. The sum of the calculations for the first unit, 0.93406, is multiplied by the Division conversion factor of $56.82 for a total of $53.07. The sum of the calculations for subsequent units, 0.69969, is multiplied by the division conversion factor of $56.82 for a total of $39.76. The total reimbursement for 3 units is $132.59. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $132.59.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $132.59, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	May 5, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.